CENTER FOR HUMAN SERVICES
Family Support/Respite Reimbursement & Authorization Form

Send completed form via mail/email/OR fax to the Center for Human Services Attn: Diane Bahner, 1500 Ewing Drive, Sedalia, MO 65301, dbahner@chs-mo.org, fax: 866-495-6424 **by the 1st or 3rd Friday per month**
Reimbursement Checks will be mailed on the **2nd and 4th Friday per month**.
Submissions received past the deadline will result in a delay in the reimbursement check being processed/mailed.

PersonServed: _____ County: _____Phone: _____

Address: _____ City: _____ Zip: _____

Respite Services: (*List dates below of when respite services were used and amount paid to provider)*

Date(s) of Service	# Hours of Respite	Provider Fees
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$

Date(s) of Service	# Hours of Respite	Provider Fees
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$

TOTAL AMOUNT of RESPITE to be REIMBURSED: $ _____

#1 Respite Provider Signature: _____ Phone #:_____

#2 Respite Provider Signature: _____ Phone #:_____

Supplies or other Services: **(Must attach receipts/invoices or bid/cost statement)**

Date(s) Received or will Receive	Description (Example: Medical Supplies, Camp Fee, Therapy, Adaptive Equipment)	Cost
		$
		$
		$
		$

TOTAL AMOUNT of other Service/Supplies/Item to be REIMBURSED: $ _____

GRAND TOTAL AMOUNT of Respite, other Service and Supplies to be REIMBURSED: $ _____

I hereby verify that the above information is accurate and complete.

Parent/Caregiver Signature: _____ Phone #:_____

PLEASE PRINT LEGIBLY BELOW:
Make check payable to: (Name of Parent/Caregiver/CAMP) _____

Mailed to: (Address) _____

City:_____ State: _____ Zip Code: _____